# PRENATAL/TISSUE TEST REQUISITION FORM

**Cytogenetic Laboratories**
Indiana University School of Medicine
635 Barnhill Dr. MS 350, Indianapolis, IN 46202
317/274-2243 (Office) 317/278-1616 (Fax)
**317/274-1053 or 317/274-2246 (Lab)**

*Cytogenetic Lab Use Only*

**CAP#: 16789-30 CLIA#: 15D0647198**

## 1) PHYSICIAN(S):

Referring Physician:_____
Address:_____
City: _____ State: ____ Zip: _____
Phone:_____ Fax:_____

Primary Physician:_____
Address:_____
City: _____ State: ____ Zip: _____
Phone:_____ Fax:_____

Genetic Counselor: _____

## *FOR LABORATORY USE ONLY:*

Date Received: _____/_____/_____ Family #: _____
Time Received: _____:_____am/pm Proband: ☐
Received By _____ Not Proband: ☐

AM: ☐ CV: ☐ TI: ☐ C: ☐ Q: ☐ N: ☐
FISH: ☐ x ____ Probes FISH **ONLY**: ☐

Handling Charge: ☐ x _____ Handling **ONLY**: ☐

Lab Comment(s):

## 2) PATIENT/CLINICAL INFORMATION *(complete all sections that apply)*:

Patient Name: _____
Address: _____
Hospital: _____
MRN: _____
Sex: ☐Male ☐Female
Date of Birth: _____/_____/_____

PATIENT LABEL

Estimated Gestational Age (EGA): _____

Gravida: _____ Para: _____ AB: _____

Date of last positive fetal heart activity: _____/_____/____

## 3) SPECIMEN INFORMATION:

Collection Date: _____/_____/_____ Collection Time:_____:_____am/pm Collected By: _____

☐ Amniotic Fluid: Fluid Amount: _____ # of Tubes: _____
☐ Chorionic Villus Sampling (CVS): Sample Size: _____ ☐ Transabdominal ☐ Transcervical
☐ Products of Conception (POC): ☐ Villi ☐ Placenta ☐ Fetal, source: _____ ☐ Other: _____
☐ Skin Biopsy (non-fetal), source: _____
☐ Other, describe: _____

## 4) REFERRING DIAGNOSES (*please check all that apply*):

☐ Advanced Maternal Age
☐ Abnormal maternal serum screen or FFDNA, increased risk of: ☐ Trisomy 13 ☐ Trisomy 18 ☐ Trisomy 21
☐ Abnormal fetal ultrasound, describe: _____
☐ Family history of chromosome abnormality, describe: _____
☐ Fetal demise
☐ Confirmation Study (following abnormal chromosome analysis)
☐ Recurrent spontaneous abortion/miscarriage ☐ Other, describe: _____
ICD-10 Code: _____

## 5) REQUESTED TESTING:

☐ Chromosome analysis (standard)
☐ Chromosome analysis to rule out mosaicism (skin biopsy only)
☐ AFP with ACHE reflex (amniotic fluid only)
☐ ACHE (amniotic fluid only)
☐ Save cultured cells for additional send-out testing
☐ Culture cells for send-out testing (no chromosome/FISH analyses)
☐ Maternal Cell Contamination Requirements-See IUMGDL Requisition Form

**FISH Analysis (if any):**
☐ Trisomy 13 ☐ Trisomy 18 ☐ Trisomy 21
☐ X/Y
☐ AneuVysion (13, 18, 21, and X/Y)
☐ Microdeletion, please indicate probe:
_____

**CONTINUES ON BACK**

## 6) SPECIMEN COLLECTION REQUIREMENTS

| Specimen | Collection | Container(s) | Instructions |
|---|---|---|---|
| Amniotic Fluid | 10-25 mL of fluid<br>Discard first 2-3 mL to avoid maternal cell contamination.<br>Place remaining fluid in 3-4 aliquots, labeled 1st, 2nd, etc. | Sterile Corning centrifuge tubes can be provided upon request.<br>For bloody specimens, use Dark Green-top sodium heparin tubes. These tubes are also available upon request by calling the lab. | **Refrigerate.**<br>**Do not centrifuge.** |
| Chorionic Villus (CVS) | 20-30 mg (50 mg if FISH testing also requested). | Transport media will be provided upon request by calling the lab. | **Refrigerate.** |
| Products of Conception (POC) | 3-10 $mm^3$<br>Villi from the placenta is the preferred sample type.<br>Fetal cartilage, membranes, and tendon will also be accepted. | Transport media will be provided upon request by calling the lab.<br>If not available, use a sterile screw-top container with sterile media. | **Refrigerate.**<br>**Do not send entire fetus.** |
| Skin Biopsy (non-fetal) | Skin punch or surgery skin specimen | Transport media will be provided upon request by calling the lab.<br>If not available, use a sterile screw-top container with sterile media. | **Refrigerate.** |

## 7) SPECIMEN HANDLING REQUIREMENTS

- Collect all specimens aseptically.
- **Do not freeze any specimen type.**
- Do not place specimens in formalin or any other fixative.
- Keep all specimens refrigerated until transport.
- Label all containers and requisition forms with patient name, MRN, date of collection, and physician name.
- **Specimens should be received within 24 hours of collection.**
- Call the laboratory at 317/274-2246 or 317/274-1053 to order any collection containers/media.

## 8) PATIENT BILLING INFORMATION:

☐ Bill Patient's Insurance: Policy #: _____ Group #: _____

Insurance/Managed Careplan: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐Other: _____ Insured's Social Security #: _____

☐ ***OR*** Copy of patient's insurance card attached

☐ Bill Medicare: _____

☐ Bill Medicaid: _____

☐ Bill Patient/Self-Pay *(Please Attach Patient Demographic Sheet)*

☐ Bill Hospital: _____